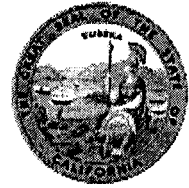




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Director

State of California—Health and Human Services Agency  
**Department of Health Services**



GRAY DAVIS  
Governor

May 16, 2002

MMCD Policy Letter 02-02  
Supercedes MMCD Policy Letter 96-6

TO: ☒ County Organized Health Systems (COHS)  
☒ Geographic Managed Care (GMC) Plans  
☒ Prepaid Health Plans (PHP)  
☒ Primary Care Case Management (PCCM) Plans  
☒ Two-Plan Model Plans

SUBJECT: SITE REVIEW

**PURPOSE**

This letter defines a standardized site review policy that complies with DHS contractual requirements, and is applicable to all Medi-Cal managed care health plan models (hereafter referred to as plans) for review of primary care provider (PCP) sites. The purpose of conducting site reviews is to ensure that all PCP sites used by plans for delivery of services to plan members have sufficient capacity to:

- 1) provide appropriate primary health care services;
- 2) carry out processes that support continuity and coordination of care;
- 3) maintain patient safety standards and practices; and
- 4) operate in compliance with all applicable federal, state and local laws and regulations.

This policy letter describes a system-wide process to minimize site review duplication and support consistency in PCP site reviews.



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## **BACKGROUND**

In 1991, the Centers for Medicaid and Medicare Services (CMS), formerly the Health Care Financing Administration (HCFA) Medicaid Bureau, as part of the Quality Assurance Reform Initiative (QARI), stipulated that provision of managed care health services must adhere to all current applicable federal, state and local statutory and regulatory requirements. CMS also required that all managed care organizations contracting with State Medicaid programs have an internal program for quality assurance. In addition, plans are required to offer a range of services, including both preventive and primary care services that meet the needs of the populations served. The site review process is the part of a plan's quality improvement program that focuses on the capacity of the PCP site to ensure and support the safe and effective provision of clinical services provided at the primary care sites within the provider network.

Primary care services include all health care and laboratory services customarily provided by or through a general practitioner, family practice physician, internal medicine physician, pediatrician, or obstetrician/gynecologist serving as a PCP, in accordance with State licensure and certification laws and regulations (Title 42, Code of Federal Regulations (CFR), Section 438.6).

Plans are required to have adequate facilities and sufficient site locations available to meet contractual requirements for the delivery of primary care within its service area (Title 22, California Code of Regulations (CCR), Section 56230).

Past efforts to ensure compliance with regulatory requirements have resulted in multiple overlapping and duplicative reviews of physician offices by various agencies, often with little or no communication between agencies. Multiple reviews have often resulted in significant disruption in the provision of patient care at provider sites. In 1998, a workgroup, composed of representatives from the commercial, local initiative, geographic managed care, and county organized health system plans, was established by the Department of Health Services (DHS) Medi-Cal managed care division (MMCD) to revise the Medi-Cal managed care site review policy. The objective of the policy revision workgroup was to develop a uniform, system-wide process that both clarifies mandated requirements and decreases duplicative site reviews for Medi-Cal managed care plan providers. This policy letter defines the site review process established by the collaborative workgroup.

## **POLICY**

Health plans are subject to requirements established in statute by Title 22, CCR, for participation in the Medi-Cal Program and Title 28, CCR, for Knox Keene-licensed health plans. Review of PCP sites is required for all health plans participating in the

Medi-Cal managed care program (Title 22, CCR, Section 56230). Plans shall ensure that PCP sites are compliant with all applicable local, state and federal standards. Each provider site, where applicable, must be licensed and accredited by appropriate agencies, and maintain compliance with all licensing standards (Title 22, CCR, Section 56230). Prior to approval for use in providing services to members, all contracted or subcontracted sites where primary health care services are provided shall be subject to an initial onsite inspection, and thereafter periodic inspections to evaluate the continuing capacity of the site to support the delivery of quality health care services (Title 22, CCR, Section 56230).

### **Accountability**

Contracting Medi-Cal managed care plans have ultimate accountability for all functions performed within their jurisdiction of responsibility, whether those functions are performed by the plan itself, or a delegated and/or sub-delegated entity. Plans are accountable for all primary care provider sites from which health care services are delivered to members. Plan accountability includes ensuring that a PCP site inspection is completed according to regulatory, contractual and policy requirements, and that all necessary corrective actions have been completed. Plans must provide ongoing oversight and monitoring of sites between reviews.

Health plans and Independent Physician Associations (IPAs) that are subcontracted for provision of health care services to plan members are accountable to the DHS-contracted plan for compliance with all applicable regulatory, contractual and policy requirements.

### **Delegation**

All delegated responsibilities must be approved by DHS. The plan is responsible for:

- establishing a formal, mutually agreed upon document;
- identifying specific delegated functions;
- overseeing and monitoring delegated activities; and
- ensuring that delegated functions are properly carried out.

All delegated and sub-delegated entities shall follow the most current MMCD site review policy requirements. Site review personnel from delegated and sub-delegated entities shall be trained, certified and supervised according to the policy standards established for contracting plans.

### **Credentialing and Recredentialing**

Plans shall ensure that providers are credentialed according to MMCD contractual and policy requirements. A site review shall be completed as part of the initial credentialing process if a new provider at a site that has not previously been reviewed is added to a contractor's provider network. A site review need not be repeated as part of the initial credentialing process if a new provider is added to a provider site that has a current passing site survey score. A site review survey need not be repeated as part of the recredentialing process if the site has a current passing site survey score. A passing Site Review Survey shall be considered "current" if it is dated within the last 3 years, and need not be repeated until the due date of the next scheduled site review survey or when determined necessary through monitoring activities by the plan.

### **Full Scope Site Review**

All primary care provider sites participating in the Medi-Cal managed care program are required by California statute (Title 22, Section 56230) to complete an initial site inspection and subsequent periodic site inspections regardless of the status of other accreditation and/or certifications. The Full Scope site review shall be the system-wide standard for conducting the initial and subsequent periodic reviews of PCP sites. A Full Scope review consists of the MMCD Site Review Survey (Attachment A) and Medical Record Review Survey (Attachment B). All contracting plans and subcontracted entities shall use MMCD survey criteria and scoring methodology for site and medical record audits.

#### **I. Initial Full Scope Site Review**

All primary care sites serving Medi-Cal managed care members shall undergo an initial site review with attainment of a minimum passing score of 80% on both the Site Review Survey and Medical Record Review Survey. The initial site review is the first onsite inspection of a site that has not previously had a full scope survey, or a PCP site that is returning to the Medi-Cal managed care program and has not had a passing full scope survey within the past three years. The initial full scope site review survey can be waived by a plan for a pre-contracted provider site if the provider has documented proof that a current full scope survey with a passing score was completed by another plan within the past three years.

Prior to initiating plan operations in a service area, an initial full scope survey shall be completed on 5% of the provider network, or on 30 PCP sites, whichever is greater in number. The 5% or 30 PCP sample sites shall include a variety of providers from throughout the provider network and/or from each subcontracted entity. If there are 30 or fewer PCP sites in the network, 100% of the sites must be completed prior to beginning plan operations. Corrective actions shall be completed as outlined in

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this policy. An initial full scope survey shall be completed on 100% of the remaining proposed PCP sites within the first 6 months of plan operation or expansion.

## II. Subsequent Periodic Full Scope Site Review

After the initial full scope survey, the maximum time period before conduction of the next required full scope site survey shall be three years. Plans may review sites more frequently per local collaborative decision, or when determined necessary based on monitoring, evaluation or corrective actions plan (CAP) follow-up issues.

### **Medical Record Review**

Ten (10) medical records shall be reviewed initially for each provider as part of the site review process and every three years thereafter. During any medical record survey, reviewers shall have the option to request additional records for review. If additional records are reviewed, scores must be calculated accordingly (See Attachment B).

Medical records of new providers shall be reviewed within 90 calendar days of the date on which members are first assigned to the provider. An additional extension of 90 calendar days may be allowed *only if* the new provider does not have sufficient assigned Medi-Cal managed care plan members to complete a review of 10 medical records. If there are still fewer than 10 assigned member records at the end of six months, a medical record review shall be completed on the total number of records available, and the scoring shall be adjusted according to the number of records reviewed.

Sites where documentation of patient care by multiple PCPs occurs in the same record shall be reviewed as a "shared" medical record system. Shared medical records shall be considered those that are not identifiable as "separate" records belonging to any specific PCP. A minimum of 10 records shall be reviewed if two to three PCPs share records, 20 records shall be reviewed for four to six PCPs, and 30 records shall be reviewed for seven or more PCPs.

### **Scoring**

The minimum passing score for the site review survey and the medical record survey is 80%. The site review survey contains a total of 150 points, with the following compliance level categories:

- Exempted Pass: 94% or above, *without* deficiencies in critical elements;
- Conditional Pass: 80-93%, or 94% or above *with* deficiencies in critical elements; and
- Not Pass: below 80%.

The Medical Record Survey contains a total of 320 points, with the following compliance level categories:

- Full Pass: 100%:
- Conditional Pass: 80-99%; and
- Not Pass: below 80%.

A full point(s) shall be given if the scored element meets the applicable criterion. Partial points shall not be given for any scored element that is considered only "partially" met by the reviewer. Zero points shall be given if an element does not meet criteria. The reviewer shall determine the "not applicable" (N/A) status of each criterion based on site-specific assessment. The reviewer must explain all criteria scored as zero points or assessed as N/A.

If a site receives a non-passing score by one plan, the site shall be considered to have a non-passing score by all other Medi-Cal managed care plans. Plans shall use the local collaborative process to identify shared providers and to define methodology and determine systems for sharing survey information.

### **Critical Elements**

Nine critical survey elements related to the potential for adverse effect on patient health or safety have a scored "weight" of two points. All other survey elements are weighted at one point. All critical element deficiencies found during a full scope site survey, focused survey, or monitoring visit shall be corrected by the provider within 10 business days of the survey date, and verified as corrected by the plan within 30 calendar days of the survey date. Sites found deficient in any critical element during a Full Scope Site Review Survey shall be required to correct 100% of the survey deficiencies, regardless of survey score. Critical elements include the following nine criteria:

- 1) exit doors and aisles are unobstructed and egress (escape) accessible;
- 2) airway management equipment, appropriate to practice and populations served, are present on site;
- 3) only qualified/trained personnel retrieve, prepare or administer medications;
- 4) office practice procedures are utilized on-site that provide timely physician review and follow-up of referrals, consultation reports and diagnostic test results;
- 5) only lawfully-authorized persons dispense drugs to patients;
- 6) personal protective equipment (PPE) is readily available for staff use;
- 7) needlestick safety precautions are practiced on-site;
- 8) blood, other potentially infectious materials (specimens) and regulated wastes (sharps/biohazardous non-sharps) are placed in appropriate leak-proof, labeled containers for collection, processing, storage, transport or shipping; and

- 9) spore testing of autoclave/ steam sterilizer is completed (at least monthly), with documented results.

### **Corrective Action Plans**

Sites that receive an Exempted Pass (94% or above, *without* deficiencies in critical elements) shall not be required to complete a CAP unless determined necessary by the plan. All sites that receive a Conditional Pass (80-93%, or 94% and above with deficiencies in critical elements) shall be required to establish a CAP to correct 100% of cited deficiencies. The plan conducting the survey is responsible for the follow-up, re-survey and closure of the CAP. CAP documentation shall identify the specific deficiency, corrective action(s) needed, projected and actual date(s) of the deficiency correction, re-evaluation timelines/dates, and responsible person(s). The closed CAP also shall include documentation of problems in completing corrective actions (if any), education and/or technical assistance provided by plan, evidence of the correction(s), completion/closure dates, and name/title of reviewer. CAP notification and completion shall occur according to following timeline:

- I. Providers with Conditional Pass score (80% or above)
  - A) At the time of the survey: reviewers shall notify providers of non-passing survey scores, critical element deficiencies, other deficiencies determined by the reviewer or plan to require immediate corrective action, and the CAP requirements for these deficiencies.
  - B) Within 10 business days of the survey date:
    - 1) providers shall submit a completed CAP with verification for all critical element and/or other survey deficiencies requiring immediate correction to the requesting plan; and
    - 2) plans shall provide a survey findings report and a formal written request for corrections of all other (i.e., non-critical, non-immediate) deficiencies to providers.
  - C) Within 30 days of the survey date, plans shall re-evaluate and verify corrections of critical elements and other survey deficiencies requiring immediate correction.
  - D) Within 30 calendar days from the date of the written CAP request:
    - 1) providers shall submit a CAP for all deficiencies (other than critical) to plan; and
    - 2) plans shall review/revise/approve CAP and timelines.
  - E) Within 60 calendar days from the date of written CAP request:
    - 1) providers shall complete all other corrective actions; and
    - 2) plans shall provide educational support and technical assistance as needed, re-evaluate/verify corrections, and close the CAP.

- F) Beyond 60 calendar days of the date of written CAP request:
- 1) providers may request a definitive, time-specific extension period (not to exceed 90 calendar days from survey findings report and CAP notification date, unless a longer extension is approved by the Department) to complete corrections if extenuating circumstances that prevented completion of corrections can be clearly demonstrated, and if agreed to by the plan; and
  - 2) plans shall re-survey any provider site in 12 months that required an extension period beyond 90 calendar days to complete corrections prior to closing the CAP.

## II. Non-Passing Pre-contractual Provider

A pre-contractual provider who scores below 80% on the full scope site review survey shall not be counted as a network provider. Prior to being approved as a network provider, a non-passing provider must be re-surveyed and pass the full scope site review survey at 80% or higher. After achieving a score of 80% or higher, a CAP shall be completed as specified under CAP timeline requirements.

## III. Non-Passing Contracted Network Provider

Providers shall be notified of the survey score, all cited deficiencies and CAP requirements at the time of a non-passed survey. Plans shall have the right to remove any provider with a non-passing score from the provider network. However, if a provider with a non-passing score is allowed to remain in the provider network, survey deficiencies must be corrected by the provider and verified by the plan within the CAP timelines established in this policy. New members shall not be assigned to network providers that score below 80% on a subsequent full scope site review survey until corrections are verified and the CAP is closed.

## IV. Non-Compliant Provider

Providers who do not correct survey deficiencies within the established CAP timelines shall not be assigned new members until such time as corrections are verified and the CAP is closed. Any network provider who does not come into compliance with survey criteria within the established timelines shall be removed from the network and plan members shall be appropriately re-assigned to other network providers. Plans shall provide affected members with a 30-day notice that the non-compliant provider is being removed from the network.

## V. Provider Appeal Process

Providers removed from the network shall have the right to appeal the decision with the plan. Plans shall have a formal and fair process to resolve grievances and complaints

submitted by providers of medical services. If verified evidence of corrections is acceptable by the plan and the decision is reversed, the plan shall repeat the full scope survey or accept the current survey and CAP as completed and re-survey the site in 12 months. If the decision is not reversed by the plan, the provider may re-apply through application processes established by the plan. All applicants shall undergo an initial Full Scope Survey, and be required to adhere to the requirements and standards established by this policy.

### **Monitoring**

Plans shall systematically monitor *all* PCP sites between each regularly scheduled full scope site review survey. Monitoring methods may include site visits, but shall also include methodologies other than site visits. Monitoring sites between audits shall include the use of both internal (e.g., quality improvement) systems and external (e.g., public health) sources of information. Evaluation of the nine critical elements shall be monitored on all sites between full scope site surveys. When problems are identified through monitoring processes, plans shall determine the appropriate course of action to assure that problems are fully investigated and corrected in a timely manner.

### **Focused Review**

The focused review is a "targeted" audit of one or more specific site or medical record review survey areas, and shall not be substituted for the full scope survey. Focused reviews may be used to monitor providers between full scope site review surveys, to investigate problems identified through monitoring activities, or to follow up on corrective actions. Reviewers may use the appropriate section(s) of site review and/or medical record review survey tools for the focused review, and/or other methods to investigate identified problems or situations. All deficiencies found in a focused review shall require the completion and verification of corrective actions according to CAP timelines established previously in this policy.

### **Local Collaboration**

Plans shall collaborate locally, within each Medi-Cal managed care county, to establish systems and implement procedures for the coordination and consolidation of site audits for mutually shared primary care providers. All contracting plans within a county have equal responsibility and accountability for participation in the local site review collaborative processes.

An initial written description and periodic update reports (as requested by MMCD) shall be submitted to the MMCD Medical Monitoring Unit nurse describing the local collaboration processes, which includes but are not limited to the following information:

- names and titles of participating personnel from each plan;
- work plan that includes goals, objectives, activities, and timelines;
- scheduled meeting dates/times/locations, meeting processes and outcomes;
- communication and information sharing processes;
- roles and responsibilities of each plan;
- delegated activities, and use of delegated and/or subdelegated entities/agencies; and
- Memoranda of Agreement (MOA) requirements established for plans and providers.

Policies and procedures shall also be established to define local collaborative methodology for the following:

- confidentiality, disclosure and release of shared provider survey information;
- oversight and monitoring of survey processes;
- site review personnel and training processes;
- collection and maintenance of a local survey information database system; and
- evaluation processes.

### **Review Personnel**

The Medical Director and/or Chief Medical Officer are ultimately responsible for site review activities implemented by plan personnel and/or contracted agency or entity. The plan shall retain site review program oversight responsibility whether survey functions are maintained within the plan, delegated to another plan, or subcontracted to a third agency or entity. Plans shall identify designated physician and/or registered nurse (RN) personnel to become certified trainers responsible for training and supervising reviewers, certifying RN and physician reviewers, monitoring reviews and evaluating reviewers for interrater reliability. Certified site review trainers may also include personnel from subcontracted agencies.

Plans shall determine the composition of the review teams performing site review surveys. A variety of personnel, such as pharmacists, dietitians and others able to provide assistance and clarification may be part of the survey team. The responsible reviewer for each survey shall be at minimum an RN, who shall sign the site review and/or medical record survey.

Reviewers shall only review survey criteria that are *appropriate* to their level of education, expertise, training and professional licensing scope of practice as determined by California statute. Plans shall have written policies and procedures that clearly define the duties and responsibilities of all review personnel. Plans shall demonstrate that survey activities established for reviewers are in compliance with scope of practice as defined by California statute, in accordance with the State licensing and/or certification agencies, and are appropriate to the reviewer's education and training.

### **Site Review Training and Certification**

Site Review trainers shall be certified as trainers, and recertified every two years thereafter. Physician and RN reviewers shall be certified as reviewers of the full scope site review survey, and recertified every two years thereafter. All reviewers shall complete site review training prior to conducting surveys, and periodically thereafter as established in the site review training program curriculum and site review certification process.

### **Site Review Data Submission Procedures**

Plans shall submit site review data to the MMCD Medical Monitoring Unit nurse evaluator every six months (See Attachment D), by June 30 and December 31 of each calendar year. Data may, at the Plan's discretion, be submitted more frequently than every six months. For pre-operational and expansion site reviews, site review data must be submitted to the MMCD Medical Monitoring Unit nurse evaluator at least six weeks prior to site operation, and then by June 30 and December 31, of each calendar year, thereafter. Data will be submitted in Microsoft Access.mdb format (version 97 or later).

## **DISCUSSION**

### **Delegation**

Plans may delegate site review responsibilities to another DHS-contracted Medi-Cal managed care plan, or subcontract responsibilities to an appropriate agency/entity. Delegation of site review responsibilities is a determination made by each plan. However, each collaborating plan shall determine the *acceptance* of surveys completed by the entities delegated or subcontracted by another local plan.

### **Credentialing and Recredentialing**

For a new provider on a site that has not previously been reviewed, initial provider credentialing and site review will occur simultaneously. As providers at a site may change over time, the timeline for provider recredentialing and subsequent site review surveys may become independent processes that are not on a synchronized schedule.

### **Full Scope Site Review Survey**

A PCP site is required to undergo an initial full scope site review if there is no evidence of a current passing survey completed by another local plan, or when a contracted provider from an approved site moves to a new site that has not previously been reviewed. An initial site survey need not be completed by a "new" contracting plan if a copy of the current passing site survey is provided by the provider or another local plan.

The most current site review and medical record surveys shall be shared with and accepted by all plans contracting with the provider. Each plan is responsible for tracking the survey status of all contracted provider sites. Plans shall collaborate locally to determine processes for notification of survey status and/or results on shared providers.

#### Medical Records

Medical records are reviewed for format, legal documentation practices, and documented evidence of the provision of preventive care and coordination and continuity of primary care services. The medical record provides legal proof of the care a patient receives. Documentation of patient care has become synonymous with the care itself. Failure to document appropriately implies failure to provide care.

Preventive care criteria cover three content areas: pediatric, adult health, and obstetric services. The medical record score is based on a survey standard of 10 randomly selected records per provider, consisting of five pediatric records and five adult and/or obstetric records. For sites with *only* adult, *only* obstetric, or *only* pediatric patients, all ten records surveyed are *only* in that preventive care area.

#### Scoring

Survey scoring is based on available documented evidence, actual demonstration of criteria being met and verbal interviews with site personnel. If a plan chooses to audit additional criteria not included on the site review or medical record review surveys, the additional criteria *cannot* be added to the existing scoring methodology. Scored criteria or assigned weights *cannot* be altered in any way. Calculation of scores is based on the total survey points, or on the adjusted survey points for "not applicable" items. For scoring procedure, see the site review survey guidelines (Attachment A) and the medical record review guidelines (Attachment B). Although an immunization checklist (Attachment C) is included for evaluation of documented immunizations, checklist information is not included in medical record scoring.

#### Corrective Action Plans

Plans have the option to require a Corrective Action Plan (CAP) for sites with an exempted pass score on the site review survey. A CAP is required on *all* cited deficiencies for sites with a conditional pass score on the site review or medical record review survey, on a focused review, or for deficiencies identified by the plan or State through oversight and monitoring activities.

Plans shall establish a process for handling providers who pass the full scope survey at 80% or higher, but fail to respond to a request for a CAP or to complete the corrective actions. Plans shall remove a provider from the network regardless of survey scores if criteria are not met or corrective actions are not taken within the established CAP time period. If removed from the network, providers may file a formal appeal to the plan.

New provider sites with a score below 80% are not eligible for participation in the Medi-Cal managed care program. At its discretion, a plan may decide to provide additional education, give supportive technical assistance, or develop a CAP with non-passing pre-contractual provider sites. Pre-contractual providers who do not pass the survey may correct deficiencies, reapply to the plan(s) and be re-surveyed. If the provider passes, the plan will follow the procedures outlined for implementing corrective actions for all cited deficiencies.

#### Monitoring

Plans are required to monitor their primary care providers between regularly scheduled site review surveys. Monitoring strategies may include information gathered through established internal plan processes, provider-and program-specific reports from external sources, focused reviews and/or onsite visit(s). When problems are identified through monitoring, plans may choose to repeat the full scope site review audit, conduct additional focused onsite reviews, or implement other appropriate methods to ensure that problems are investigated and corrected.

#### Local Collaboration

In 1998, Assembly Bill 162 (CA Health and Safety Code, Section 1342.8) required the streamlining of regulatory processes and the reduction in redundant reviews of offices of physicians by coordinating, to the extent feasible, as many of those regulatory functions as possible. In each county, plans shall determine the collaborative processes, systems and methods that will be used locally to coordinate review processes and decrease redundant site visits. Site review responsibilities may be shared equally by all plans within a county, delegated to one or more plans or individual physician practices (e.g., IPA), and/or subcontracted to other agencies/entities. All plans are responsible for the coordination and consolidation of provider site reviews, and therefore share responsibilities for defining the local process.

#### Level of Reviewer

Physicians are responsible for the oversight and implementation of peer review determinations regarding the appropriateness of medical care and treatment. However, the California Legislature recognizes the existence of overlapping functions between physicians and RNs and permits the sharing of functions within organized health care systems that provide for collaboration between them (CA B&P Code, Division 2, Chapter 6, Article 2, Section 2725 (a)). Activities that overlap the practice of medicine may require adherence to a standardized procedure when it is the RN who determines that they are to be undertaken (CA B&P Code, Section 2725).

The RN is the minimal level of reviewer acceptable for *independently* performing the full scope site review survey. RN reviewers can *independently* make determinations regarding "direct and indirect patient care services that insure the safety, comfort,

personal hygiene, and protection of patients, and the performance of disease prevention and restorative measures" (CA Title 16, Chapter 14, Section 1443.5 (2)). Additionally, RN reviewers can *independently* make determinations regarding implementation of appropriate reporting or referral of abnormal survey findings to initiate peer review procedures. RNs can only delegate tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated (CA Title 16, Chapter 14, Section 1443.5 (4)).

LVNs, described by the CA Board of Licensed Vocational Nursing and Psychiatric Technicians as "dependent" practitioners and "entry-level health care providers responsible for rendering basic bedside nursing care under the direction of a physician or registered nurse," *cannot* be utilized as independent practitioners. State statute stipulates that the LVN shall perform only manual skills under the direction of a licensed physician or licensed professional nurse, and/or perform only basic data collection (CA B&P Code, Section 2859, Section 2518.5). The performance of manual skills or basic data collection does not include evaluation, analysis, interpretation or synthesis of survey information or data, and/or making determinations about the information or data that was collected. Although an LVN may collect basic explicitly defined data, he/she cannot evaluate or analyze the data. Therefore, LVN reviewers cannot independently review any site or medical record, but, as part of a survey team, can collect basic data on those survey elements that have been identified by DHS and the CA Board of Vocational Nursing and Psychiatric Technicians as within the LVN scope of practice.

Non-licensed, non-registered, non-certified personnel and dependent licensed medical personnel may be members of a site survey team as appropriate, but cannot be utilized as *independent* site reviewers.

#### Reviewer Training and Certification

Plans are responsible for ensuring that all reviewers conducting site review and medical record review surveys are appropriately trained, monitored and evaluated. Plans may collaborate to determine local systems for training and certifying reviewers. Training shall include attendance at educational seminars provided by MMCD, and may include periodic classes conducted collaboratively by one or more plans, individual or small group training sessions provided by a certified site review trainer, and/or completion of self-study learning packets.

#### Site Review Data Submission Procedures

MMCD Office of Clinical Standards and Quality (OCSQ) will distribute to all plans an Access database containing all necessary tables and data input forms. Although use of this database for data entry and storage is optional, its use for data submission is not. Site review data that is submitted in non-conforming formats will be rejected.

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DHS Responsibility

MMCD shall collaborate with plans to develop, implement and evaluate Site Review training and certification, revise training curriculum and materials as needed, and provide technical assistance to site review trainers. The training curriculum includes self-learning modules, lesson plans for didactic instruction, and guidelines for trainer and reviewer certification.

MMCD shall oversee and monitor plans for implementation of the site review policy. Monitoring areas may include, but are not limited to, oversight of plan methodology for monitoring provider sites between full scope site reviews, use of the appropriate level of reviewer according to established scope of practice legislation and the standards outlined in this policy, and local collaborative processes. Monitoring methodologies may include, but are not limited to, participation in local collaborative processes, observation of reviewer training and certification processes, assessment of data collection methodologies, and evaluation of aggregate reports.

If an onsite review is done as part of the MMCD monitoring activities, plans will be notified in advance of the date established for commencement of the onsite survey. In general, plans shall notify providers of onsite inspections whether conducted by the Department or by the plan(s). However, inspection of plan facilities or other elements of a survey may be conducted, without prior notice, either in conjunction with the medical survey or as part of an unannounced inspection program (Title 28, CCR, section 1300.80).

If you have any questions regarding this policy letter, please contact your contract manager.



Cheri Rice, Chief  
Medi-Cal Managed Care Division

Attachment

